Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RONALD G. CORLEY, MD
10109 MC KALLA PLACE, STE E
AUSTIN, TX 78758

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2468-01

MFDR Date Received
March 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "per Medical Fee Guidelines"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for the reimbursement of workers' compensation specific services rendered on or after March 1, 2008.
3. 28 Texas Administrative Code §133.20 sets out guidelines for medical bill submissions by a health care provider.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 13, 2012
   - 1 – (97) – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 1 – This procedure is included in another procedure performed on this date.

   Explanation of benefits dated February 28, 2012
   - 1 – (97) – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 1 – This procedure is included in another procedure performed on this date.

Issues

1. What are the guidelines for reimbursement of a Division ordered Designated Doctor Exam?
2. Was the Designated Doctor exam billed and reimbursed appropriately per 28 Texas Administrative Code §134.204 (i)?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (i)(1)(A-B) states, "(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor." For the billing and reimbursement of an MMI evaluation 28 Texas Administrative Code §134.204(j) (3)(C) states, "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350. 28 Texas Administrative Code §134.204(j) (4)(C)(ii)(I) &(iii) state, "(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas; (ii) The MAR for musculoskeletal body areas shall be as follows: (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used; (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR." 28 Texas Administrative Code §133.20 (c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."
2. A review of the requestor's documentation finds a copy of a bill (CMS-1500) for date of service December 8, 2011. The bill indicates that the requestor billed with CPT codes 99456-W5-WP (one unit), 99456-W5-WP (1 unit) and 99456-W6-RE (1 unit) for a Division ordered Designated Doctor Exam to determine Maximum Medical Improvement (MMI) and Impairment Rating (IR). The requestor listed CPT codes: 99456-W5-WP, 99456-W5-WP and 99456-W6-RE on the Table of Disputed Services, however, the requestor is only seeking reimbursement for one of the 99456-W5-WP codes billed. A review of the medical records finds that the requestor should have been reimbursed $350 for the attainment of maximum medical improvement in accordance with28 Texas Administrative Code §134.204(j)(3)(c) and $150 for the impairment rating of the right knee (lower extremities) in accordance with 28 Texas Administrative Code §134.204(j) (4)(C)(ii)(I)&(iii). Further review of the requestor's submitted documentation finds a copy of the initial and reconsideration explanation of benefits. The explanations of benefit indicate a payment was made to the requestor in the amount of $500 for CPT Code 99456-W5-WP. The Division concludes that the requestor has been reimbursed appropriately in accordance with 28 Texas Administrative Code §134.204 (j).
3. In accordance with 28 Texas Administrative Code §134.204 and 28 Texas Administrative Code §133.20 the respondent appropriately denied additional payment for services rendered. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/15/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.